

PERSONAL & FAMILY HISTORY (please place an "X" in the WHITE boxes that apply)

PATIENT PAST MEDICAL HX & FAMILY HX

	You	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or sisters	Children	OTHER family members
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida....)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (ex. ITP, sickle cell...)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis...)										
Glaucoma										
Heart disease or MVP										
High cholesterol										
High blood pressure										
Kidney Disease/stones										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disease										
Uterine anomalies										
...Still Living?	X									
...Deceased at Age?	----									

OTHER DISEASES/ILLNESSES:

SOCIAL HISTORY

Marital Status (please check one):

Single/Not Dating Married
 Single/ Dating Divorced
 In a committed relationship Widowed
 Engaged

PARTNER'S NAME: _____ **Age:** _____

Safety: Do you feel safe in your current relationship: Yes No
 If not please explain _____

Have you ever been physically abused in a relationship: Yes No
 If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
 If so, please let us know when this occurred: _____

Substance Use: Do you drink alcohol: Yes No
 How many drinks per day or week: _____
 Do you currently use any illicit drugs: Yes No
 Type _____
 How often _____
 Do you smoke cigarettes: Yes No
 How many per day _____
 How long have you been a smoker: _____

Occupation: _____

Do you Exercise: Yes No
 Type _____
 How often _____

Infection Risk:
 Are you currently sexually active? Yes No
 Sexual preference (circle one): Heterosexual Lesbian Bisexual Other
 How many sexual partners in the last 1 year? _____
 In your lifetime: 1-5__ 5-10__ 10-20__ 20+__

Have you ever had a sexually transmitted disease (STD)? Yes No
 Hepatitis (Type?) _____
 Syphilis (when? treated?) _____
 Chlamydia (when? treated?) _____
 Gonorrhea (when? treated?) _____
 Genital Herpes (taking meds?) _____
 HPV (human papilloma virus) _____
 Genital warts? _____
 OTHER _____

PRINT NAME HERE: _____

REVIEW OF SYMPTOMS

Constitutional:

Frequent Fatigue
Excess weight gain
Excess weight loss

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A

Eyes, Ears, Nose, Mouth:

Frequent or severe headaches
Frequent lightheadedness

Circle One:

Current Past N/A
Current Past N/A

Breasts:

Lumps
Pain
Swelling
Nipple discharge

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Cardiovascular:

Chest pain
Fainting
Swollen/Painful varicose veins
Calf pain

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Respiratory:

Frequent shortness of breath
Frequent Hoarseness

Circle One:

Current Past N/A
Current Past N/A

Gastrointestinal:

Nausea/ Vomiting
Frequent Diarrhea
Frequent Constipation
Frequent Heartburn/ reflux
Abdominal Pain
Blood in stool
Hemorrhoids

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Genitourinary:

Urgency
Frequency
Pain with urination
Blood in urine
Frequent Urine leakage
Pain with intercourse
Genital sores

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Genitourinary (continued)

Irregular periods
Painful periods
Heavy periods
No periods
Possible pregnancy?
Abnormal vaginal discharge
Significant PMS

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Integument (skin):

New skin lesions
Changes to moles/skin lesions

Circle One:

Current Past N/A
Current Past N/A

Musculoskeletal:

Joint pain
Joint swelling
Recent back pain

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A

Endocrine:

Excess bodily hair growth
Excess hair loss
Cold intolerance
Heat intolerance
Acne
Thyroid abnormalities/ treatment?

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Psychiatric:

Frequent Anxiety
Frequent Depression
Suicidal thoughts
Psychiatric treatment

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Hematologic/Lymphatic:

Easy bleeding
Easy bruising

Circle One:

Current Past N/A
Current Past N/A

List any other symptoms bothering you today: _____

YOUR HEIGHT: _____ YOUR WEIGHT: _____

PRINT NAME HERE: _____

PATIENT SIGNATURE: _____ DATE COMPLETED: _____

RENAISSANCE WOMEN'S GROUP, PA

Genetic Screening Questionnaire

NAME: _____

Will you be 35 years old or older at your due date? Y N

Are you or your baby's father of...

- Jewish background? Y N
- Black/African background? Y N
- Mediterranean background? Y N
- Asian background? Y N
- French-Canadian background? Y N

Have you...

- taken any medications (prescribed or OTC) during this pregnancy? Y N
- had any alcohol (beer, wine or hard liquor) during this pregnancy? Y N
- used any illegal/street drugs (cocaine, marijuana) during this pregnancy? Y N
- taken Accutane, blood thinners, or lithium since your last period? Y N
- had radiation therapy or chemotherapy since your last menstrual period? Y N
- take mega dose vitamins, especially vitamin A since your last period? Y N

Do you or your baby's father have epilepsy?

- and take medication? If yes type _____ Y N

Do you have diabetes or have you had diabetes with pregnancy and are/were you....

- on insulin Y N
- on oral hypoglycemic medications Y N
- controlled by diet Y N

Are you and the father of your baby first cousins or closer?

Y N

Have you had...

- three or more miscarriages? Y N
- had a stillborn infant? Y N
- a child that died within the first year of life? Y N

Have you, the father of your baby, or anyone in either family ever had a child

- | | <u>self</u> | <u>father</u> | <u>family</u> |
|---|-------------|---------------|---------------|
| • with Down Syndrome or other chromosomal abnormality? | Y N | Y N | Y N |
| • with mental retardation? | Y N | Y N | Y N |
| • with an open spine (spina bifida), skull defect, or anencephaly? | Y N | Y N | Y N |
| • with a heart defect? | Y N | Y N | Y N |
| • with a muscle or neuromuscular disease (muscular dystrophy)? | Y N | Y N | Y N |
| • with Cystic Fibrosis? | Y N | Y N | Y N |
| • with Hemophilia, sickle cell, thalassemia, or other blood disorder? | Y N | Y N | Y N |
| • with any birth defect or genetic disease not listed above? | Y N | Y N | Y N |

Patient signature _____ *Date* _____

RENAISSANCE WOMEN'S GROUP
PATIENT AUTHORIZATION FORM

Please.....read, initial, and sign below

(Initial)_____ FINANCIAL RESPONSIBILITY: I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles. Claims will be filed for PPO and HMO participants, Medicare and Medicaid. Payment of benefits will be made directly to Renaissance Women's Group.

(Initial)_____ INSURANCE COVERAGE: I understand that I am responsible for providing RWG with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. (_____ RWG Staff Initials)

(Initial) I DO _____ I DO NOT _____ CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, nurse practitioner or physician's assistant as is necessary in his/her judgment, with patient approval. **Separate consent forms will be signed for procedures performed in the physician's office.**

(Initial)_____ RELEASE OF INFORMATION: I do hereby authorize Renaissance Women's Group to release information to North Austin Medical Center (NAMC) or St. David's Medical Center in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)_____ HIPAA: I acknowledge that I have received a copy of RWG's Notice of Privacy Practices.

(Initial)_____ FEE FOR FORMS COMPLETION: I understand that I will be responsible for paying \$15 for forms completion by RWG physicians or staff. (Example: Disability forms, FMLA forms, etc.)

(Initial)_____ FEE FOR 'NO SHOW'. I understand that a \$25 'no show' fee will be assessed for appointments that I do not keep.

Spouse's Name: _____ Spouse's Work Phone: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Emergency Contact: _____ Emergency Phone: _____
(other than spouse)

Patient Name: _____ **Signature:** _____

Today's date: _____

Renaissance Women's Group (OB)

12201 Renfert Way Austin, Texas 78758

Patient Name:	Appointment Date:	Today's Date:
----------------------	--------------------------	----------------------

Please bring this completed form with you to your next appointment

We are pleased you have chosen Renaissance Women's Group and look forward to providing consistent high quality medical care and related services to you. To avoid confusion about your insurance coverage we ask that you contact your insurance company prior to your next appointment to understand your specific plan benefits and coverage. Please be aware that we will bill you privately for any charges not covered by your plan, so time taken now on your part will eliminate unexpected expenses to you later. **This form is to be used as a guide when calling your insurance company regarding your benefits.**

Name of Insurance Company	Insurance Phone number for benefits	Insurance representative spoke with:
Insurance policy holder's name: <hr/>	Policy holder's Social Security #: <hr/>	Policy holder's employer's name: <hr/>
Policy holder's date of birth: - - 19__ __	<hr/> - - -	Policy Effective Date: <hr/> - - -

To find out if RWG is a participating provider on your plan, give the insurance representative our Tax ID # 74-2760437

- 1). **What type of plan do I have?** ___HMO ___PPO ___POS ___Managed Care ___Indemnity
Verify with your insurance that the doctor that you are scheduled with is a contracted provider (IN NETWORK) for your type of policy. If you are seen by a physician at RWG and you are out of network, you will be responsible for the payment of these services to RWG. Please be aware that RWG may be contracted with your insurance but not for your plan type. For example, we are contracted with Cigna PPO but we are not contracted with Cigna HMO, POS and Managed Care.

- 2). **Is Clinical Pathology Labs an IN-NETWORK Lab (Tax Id 74-2554159)?** ___YES ___NO...if not, what lab is in-network_____

- 3). **Do I have OB GLOBAL (antepartum, delivery and postpartum visit) maternity benefits?** ___YES ___NO
 If so, how is it covered? ___100% ___90% ___80% or _____
 Do I have a deductible to meet? ___YES ___NO If YES, deductible amount? \$_____ What is met? _____
The percentage that your insurance does not cover will be DUE to RWG by your second OB visit

- 4). **Does my delivery require pre-certification for my delivery?** ___YES ___NO
 If so, what is the phone number to call to obtain the pre-certification? _____

- 5). **Do I have coverage for all Ultrasounds done during my pregnancy?** ___YES ___NO
 If so, coverage? _____
 Is a referral or authorization required? ___YES ___NO

- 6). **Is North Austin Medical Center an in-network hospital on my plan (Tax Id 74-2781812)?** ___YES ___NO

- 7). **Does my policy cover permanent sterilization (tubal ligation)?** ___YES ___NO

- 8). **Is Circumcision covered by my plan?** ___YES ___NO
 If so, is **pre-certification** required for circumcision? ___YES ___NO
 If so, what is the phone number to call? _____

If at any time, while you are a patient at **Renaissance Women's Group**, you change your PCP, insurance plan, or are informed of contract change, it is your responsibility to immediately inform our business office.

-THANK YOU -